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Helping asthma patients to stop smoking

Sir,

The management of asthma has two basic components, pharmacological and educational.[1,2] The pharmacological component comprises ensuring that patients receive appropriate medication, usually in the form of inhalation therapy, and ensuring that the most appropriate delivery system is used.[1] The educational aspect usually centres around ensuring correct and appropriate use of inhaler devices, with information also given regarding the pathophysiology of the disease, the therapeutic effects of any medication prescribed, and general advice regarding avoidance of trigger factors.[2]

Smoking is well recognized as a major cause of respiratory morbidity and mortality. While smoking undoubtedly plays a role in the pathophysiology of asthma, there has been surprisingly little work to measure this.[3-6] There are no reliable figures for the number of asthma sufferers who smoke, and whether interventions aimed at decreasing smoking levels in this group can improve control of asthma.

Between June and August 1993, asthma sufferers in an inner city general practice were surveyed regarding their smoking habits. The practice is a five partner inner city practice which has an asthma clinic supervised by a practice nurse trained in asthma management. The list size is 6788 patients. Using the practice computer, 258 asthma sufferers between the ages of 16 and 65 years were identified. The notes of these patients were tagged and a simple questionnaire inserted. These questionnaires were completed opportunistically by the doctors or practice nurses. A total of 110 questionnaires were completed over a three-month period. Of the 110 respondents 35.5% admitted smoking while 71 (64.5%) said they did not smoke. Twenty five of the 39 smokers said they would like to give up (64.1%). As a result of this study, a stop smoking clinic was instituted specifically aimed at asthma sufferers. This was unsuccessful as only one person agreed to attend the clinic. This highlights the problems associated with attempting to educate patients with chronic respiratory disease to stop smoking.

If the number of asthma sufferers who smoke really is in the region of 30%, more education should be directed at getting people with asthma who smoke to stop; and if a reduction in the number of asthma sufferers who smoke could reduce the need for medication, this would have profound economic implications. Our study, however, suggests that persuading people with asthma to stop smoking will not be easy.

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Trainees' out of hours work

Sir,

Out of hours work and night visits remain a major cause of concern among trainees as well as principals in general practice.[1] Informal discussion with trainees reveals wide variation between training practices in rotas and in support from trainers. In the hope of promoting further debate a postal survey was undertaken of Leicestershire vocational training scheme trainees in general practice in January 1994. The questionnaire comprised open and closed questions, which sought information on practice arrangements, and trainees' views and experiences. Of 25 trainees, 21 replied (84%).

Rotas ranged from being on call one night in three to one in 13, or not at all, with all but four trainees doing the same rota as trainers. Two trainees claimed to be doing more time and two trainees claimed to be doing less time on call than their trainers or practice partners. Twenty four per cent of trainees were in practices which used deputies to some extent, including one practice which used them for practice partners but not for the trainee.

Of 21 trainers, 57% had never accompanied their trainees on night visits; 29% had done so on the first night only. Of trainees 71% felt they had gained valuable experience and 76% were happy with their out of hours commitment. However, 86% felt they should receive some form of payment, as currently night visit fees earned by trainees are paid to their practices.

The main priorities identified from this survey are the need for standards to be set for the proportion of out of hours work done by trainees, and for the level of support trainees should be able to expect. There was agreement among trainees that this work represents valuable educational experience and it would be encouraging to see this acknowledged and developed by the Royal College of General Practitioners. We would welcome any further views from both trainees and trainers.

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Reference

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Stinging nettles for osteoarthritis pain of the hip

Sir,

I would like to report a case of a patient using stinging nettles (*Urtica dioica*) as a treatment for pain from osteoarthritis of the hip.

I saw the man at the end of April 1994 who had been complaining of pain over the left hip joint for the previous six months. This had made it difficult for him to walk up hills and he had been unable to ride a bicycle as previously. Apart from that, he was a fit man for his 81 years of age and still took part in local amateur dramatics. I referred him for an x-ray of his hip and prescribed ibuprofen tablets. The x-ray showed definite osteoarthritis and joint space narrowing. He returned to see me in mid-July to inform me that the prescribed tablets had been no help, but in recent weeks he had been applying stinging nettle leaves to the region of his left hip. It had produced a remarkable improvement. In fact, he had been almost free of pain for some weeks and now only had to apply the stinging nettles every few days. He was able to stand on either leg and was riding his bicycle up to 10 miles a day with no pain.

I have since spoken to an elderly woman who for years has successfully

treated her swollen, red, inflamed fingers with an application of 'red nettles, which are better than green ones'. Could their pain relief have been a result of an acupuncture-like effect or caused by a chemical in the nettle? I should be interested to hear from any other general practitioners who have heard of similar cases where arthritic pain has been eased by stinging nettles.

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Diabetic patients' recommendations for better care

Sir,

It is always enlightening for doctors to hear a frank opinion of what patients think of the service they are providing. In 1993 at a conference of voluntary groups of the British Diabetic Association, some 300 people with diabetes and their carers discussed the motion 'Doctors do not understand what it is like to live with diabetes'. Strong feelings were expressed and helpful recommendations made as to how the service could be improved.

Lack of understanding of the enormous emotional and psychological effects of the condition on both patients and carers, an impression of not trusting patients to manage their own diabetes, and intimidation were common perceptions. Worst of all, perhaps, was the impression that often doctors appeared not to listen. Not surprisingly, these perceptions diminished patients' confidence in the clinician.

However, there was an understanding that for doctors, diabetes care was often only a small part of their clinical work and that it was unreasonable to expect priority for people with diabetes over other patients. People also accepted that individual patients' reactions differed, making it harder for doctors to understand each person's unique needs. Happily, some people reported that their doctors did respond to patients as people rather than cases.

On the organizational side, lack of continuity of care was reported, and a failure to involve family members in the care programme was seen to be a major failing. There were worries that the introduction of mini-clinics might outstrip the availability of general practitioners and nurses with skills in diabetes care, and there was unease that some general practitioners might be influenced by financial considerations to under-refer.

Specialist nurses and practice nurses were generally seen to be beneficial. They were more likely to have greater understanding and sympathy than doctors, but questions were raised about the quality of their training. It was strongly felt that practice nurses and 'ordinary' ward nurses needed to be appropriately trained before working with diabetic patients, and that reception staff would benefit from basic training to enable them to help in emergency diabetic situations.

Better training in 'people skills' was seen to be important, especially as people with diabetes needed to be given information on how to take on the considerable responsibility of their own care. Not surprisingly it was thought that the ideal professional carer really needed to have experienced the condition to understand fully about living with diabetes.

The conference agreed to ask the British Diabetic Association to help improve communications and relationships between doctors and their patients and carers in order to achieve good care for all people with diabetes. The following suggestions were made:

- use of a checklist for patients and doctors to ensure essential aspects of care are covered in the consultation;
- doctors to involve carers more;
- guidelines needed for good care;
- doctors to be informed of the advice in the British Diabetic Association 1992 leaflet *Diabetes care, what you should expect*;
- doctors to be involved with local British Diabetic Association branches;
- training for doctors and support staff in the emotional and psychological aspects of diabetes;
- appointment of more diabetes specialist nurses and better training in diabetes care for nurses caring for patients admitted to hospital;
- general practitioner mini-clinics to be set up only after practices have received all necessary training.

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Community pharmacy

Sir,

Separating prescribing and dispensing is claimed by various ministers of health or their civil service staff to ensure that the skills of doctors and pharmacists are used to best effect. This is no longer a sustainable proposition. Fresh, consumer-sensitive, risk-reducing and cost-effective solutions are overdue. One thousand million pounds could be released by the integration of pharmacy skills into general practice.

In 1993–94, £747 million will be spent on pharmacy services (Baroness Cumberlege, House of Lords written answer to a parliamentary question, 21 October 1993). 'Pharmacy distribution of medicines costs up to 30–40% of the total medicines bill. Should the public really be paying this amount?' (Parr C, address to the annual meeting of the College of Pharmacy, 1992). Subsidizing over 12 000 pharmacies through National Health Service dispensing is inappropriate; NHS dispensing can be better organized for the convenience of patients, and the funds redistributed.

Two surveys, the first reported by Parr in his address to the annual meeting of the College of Pharmacy in 1992, and the second a National Opinion Polls survey undertaken in 1994, show that 95% and 52% of patients, respectively, want their prescriptions dispensed at the surgery; only 6% currently enjoy this.[1] It appears there is a major unaccommodated preference.

Pharmacist supervision of dispensing is hardly needed.[2] The Nuffield report observes: 'The dispensing of many prescriptions could be shown... not to have required the personal attention of a pharmacist.'[1]

NHS dispensing should be provided in general practice by technicians. Primary care pharmacists as partners (perhaps one between six to 10 general practitioners) would bring the profession properly into integrated primary care, facilitating a one-stop service, maintenance of surgery dispensary standards, audit, interprofessional communication, adverse drug reaction reporting, postmarketing surveillance, formulary creation and maintenance, and budget management.

These changes would reduce costs dramatically. Primary care pharmacy's salary bill (where an annual salary of £30 000 is assumed) would be between £105 million and £150 million compared with current spending of £747 million, suggesting annual savings of up to £642 million. High street pharmacies should be given a separate complementary role outside the public sector.

The £425 million savings identified by the Audit Commission[3] could be equalled or exceeded by closer cooperation between pharmacist and general practitioner. The total potential annual savings realizable by adopting the strategy outlined here could exceed £1000 million.

It is demonstrably untrue that restricting dispensing to pharmacies is best for the